

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-03-2719.M4**

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 6-5-01 through 7-17-01.
- b. The request was received on 2-8-02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFAs
 - c. EOBs
 - d. Example EOBS
 - e. Medical Records
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Response to a Request for Dispute Resolution
 - b. HCFAs
 - c. EOBs
 - d. Example EOBS
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 4-11-02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 4-16-02. The response from the insurance carrier was received in the Division on 4-30-02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 4-4-02:
“The services provided are for chronic pain management, CPT Code 97799-CPAP. The TWCC Fee Guidelines do not set a fee for CPT 97799-CPAP, but state that they are to be paid DOP or dependant on the procedures documented. (Provider’s) position is that the fees paid for these services by the carrier were not ‘fair and reasonable’. Evidence supporting our position is offered in the following 5 points: 1. Examples of what other insurance companies reimbursed (Provider) for CPT 97799-CPAP during the service dates...2. The fee guidelines state that fees charged for participation in a chronic pain management program are to be ‘bundled’ as opposed to billing for the various components of an employee’s treatment...3. (Provider) is also enclosing a study it conducted in 2001. The study surveyed what insurance companies were paying for CPT 97799- CPAP...”.
2. Respondent: Letter dated: 4-30-02:
“A program of chronic pain management was originally preauthorized for the period of 5/29/01 to 7/5/01 and extended to 7/17/01. The **Texas Medical Fee Guidelines list procedure code 97799** as requiring documentation of procedure and provides for reimbursement at a ‘fair and reasonable rate’. (Carrier) reimburses these services at a fair and reasonable rate of **\$125 per hour** for an accredited provider and \$100.00 for a non-CARF accredited facility. Charges were originally denied with an ‘F’ stating that services were paid according to the provisions of the Medical Fee Guidelines as explained in paragraph two. Since learning the Commissions position regarding the use of ‘M’ for reductions of payments on Chronic Pain Programs, we have developed the capability in our system of creating that code...Pain management programs are structured to provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve functioning and decrease the dependence on the health care system. (Carrier) reimburses these services at a fair and reasonable rate of \$125 per hour for an accredited provider and \$100.00 for a non-CARF accredited facility. This is the result of extensive review of all identifiable Chronic Pain Management Programs across the state of Texas. All contacted providers found our consistent reimbursement of \$125 per hour to be acceptable. From information obtained from these providers, a ‘standard’ CPM program was identified and evaluated at a ‘per modality’ rate according to the Texas Fee Guidelines. Based upon that review, the per hour reimbursement would be \$116.00. Our \$125.00 rate allows an additional \$9.00 per hour to cover the cost of Medical Management, Case Coordination, etc. Attached documentation illustrates our consistent reimbursement of this rate. Examples also show other providers who bill at this ‘fair and reasonable’ rate and those who do bill more accept our consistent reimbursement of the determined rate.”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 6-5-01 through 7-17-01.
2. The carrier denied the billed services as reflected on the EOBs as “M – Z436 – (F) CHRONIC PAIN MANAGEMENT”; “F – Z560 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY VALUES AS ESTABLISHED BY INGENIX”; “F

The above Findings and Decision are hereby issued this 12th day of February 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$11,900.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 12th day of February 2003.

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division